1.0 Description of the Service

The Maternity Care Coordination program provides formal case management services to eligible women during and after pregnancy and intervention as early in pregnancy as possible to promote healthy pregnancy and positive birth outcomes. Maternity Care Coordination services must be provided by a qualified care coordinator. The process consists of successful completion of the following activities:

Outreach
Assist potentially eligible clients in applying for Medicaid, develop a strong referral network, and increase community awareness of expanded Medicaid coverage and benefits.

Recruitment
Encourage clients to enroll in the Maternity Care Coordination program. This includes evaluating Medicaid status, explaining Maternity Care Coordination services, and obtaining the client's consent.

Assessment
Determine client's strengths and needs, including psychosocial, nutritional, medical, educational, and financial factors.

Service Planning
Develop an individualized description of what services and resources are needed to meet the needs of the client and provide assistance in accessing those resources.

Coordination and Referral
Assist the client in arranging for appropriate services, ensure that appropriate services are received and that there is continuity of care.

Follow-up and Monitoring
Assess ongoing progress and ensure that services are delivered.

Education and Counseling
Educate and inform the client in preparation for childbirth and parenting. Guide the client and develop a supportive relationship that promotes the plan of care.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 Limitations

Pregnant and postpartum women who receive Medicaid are eligible for this service.

Note: Postpartum is defined as the period of time from the last day of pregnancy through the last day of the month in which the 60th post-delivery day occurs.

2.3 Special Provisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition identified through a screening examination. While there is no requirement that the service, product or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. § 1396d(a). Service limitations on scope, amount or frequency described in this coverage policy do not apply if the product, service or procedure is medically necessary.

The Division of Medical Assistance's policy instructions pertaining to EPSDT are available online at http://www.dhhs.state.nc.us/dma/prov.htm.

3.0 When the Service is Covered

Maternity Care Coordination services are covered during pregnancy and through the end of the month in which the 60th postpartum day occurs.

Maternity Care Coordination services are covered for women who experience a spontaneous abortion (miscarriage), a therapeutic elective abortion, fetal demise or molar pregnancy through the end of the month in which the 60th postpartum day occurs.

4.0 When the Service is Not Covered

Maternity Care Coordination services are not covered when the criteria listed above are not met.

5.0 Requirements for and Limitations on Coverage

Maternity Care Coordination services include assessment, development, implementation, and evaluation of the plan of care for pregnant and postpartum women.

5.1 Enrollment

Enrollment in the Maternity Care Coordination program must be a one-on-one, face-to-face encounter. Explanation of the services and that the service is voluntary are part of the enrollment process. Enrollment in the Maternity Care Coordination program should be in the client's county of residence. Clients receiving prenatal care in the private sector are also eligible to participate in the Maternity Care Coordination program.

A pregnant or postpartum woman is enrolled in the Maternity Care Coordination program when she has signed the Letter of Agreement (DMA-3004 Rev. 10/99) or the approved equivalent indicating her desire to participate in the program and designating her Maternity Care Coordinator. The Letter of Agreement may also indicate a secondary

Maternity Care Coordinator to assist in care coordination in the absence of the primary Maternity Care Coordinator.

Immediately following enrollment in the Maternity Care Coordination program, the Maternity Care Coordinator must complete the Family Strengths/Needs Assessment (DMA 3006 Rev. 5/00) or the approved equivalent.

5.2 Initial Assessment

The goal of the initial assessment is to establish rapport with both the client and care providers; to provide assistance in meeting the service objectives; and to establish a schedule for follow-up assessments that addresses the service objectives and meets minimum program requirements for frequency of client contact. A Maternity Care Coordinator must complete the initial assessment. The components of the initial Maternity Care Coordination assessment are:

- Determine the current status of Medicaid eligibility.
- Explain Maternity Care Coordination services to the client.
  - Help the client locate providers and services.
  - Assist the client in planning visits to providers and arranging for transportation when needed.
  - Develop a plan of care with input from the client and the medical prenatal care provider to help ensure the best possible pregnancy outcome based on the client's needs.
  - Assist in the completion of forms and paperwork as required for other programs.
  - Work with the providers, especially prenatal care providers, to make sure the plan of care is followed and revised if necessary.
  - Listen to the client's needs and concerns and integrate them into the plan of care.
  - Help the client plan for the continuing health care of her child(ren).
  - Provide information about other services available within the community for the client's use.
- Explain Maternity Support services to the client.
  - coverage of pregnancy-related medical services
  - transportation
  - prescriptions
  - childbirth and parenting classes
  - dental care
  - Maternal Care Skilled Nurse Home Visit
  - Health and Behavior Intervention
  - Medical Nutritional Therapy
  - newborn Medicaid coverage
  - Home Visit for Postnatal Assessment and Follow-up Care
  - Home Visit for Newborn Care and Assessment

Note: Enrollment in the Maternity Care Coordination program is not necessary in order to benefit from Maternity Support services.

- Explain the client's responsibilities while receiving Maternity Care Coordination services.
  - ♦ Select a primary care provider and give the name of the Maternity Care Coordinator.
  - ♦ Agree to work with the Maternity Care Coordinator to develop a plan of care based on the client's identified needs.
  - ♦ Agree to follow the plan of care as developed by the client, Maternity Care Coordinator, and the prenatal care provider.
- Obtain the client's signature on the Letter of Agreement.
- Complete the Family Strengths/Needs Assessment form.
- Refer the client to the Women, Infant, and Children (WIC) Special Supplemental Nutrition program.
- Provide client/prenatal education.
  - ♦ Counsel the client about the importance of early and continuous prenatal care.
  - ♦ Assist the client in finding a prenatal care provider, if necessary.
  - ♦ Ensure that the client has received health education materials.
  - ♦ Provide information on childbirth or parenting classes available in the agency or community.
  - ♦ Provide information on tobacco usage, second-hand smoke, and smoking cessation programs.
  - ♦ Provide information on substance/alcohol usage during pregnancy and assist with locating support groups/treatment.
  - ♦ Advise against the use of any drugs/medications during pregnancy unless prescribed by a prenatal care provider.
  - ♦ Encourage the client to adhere to the prenatal care provider's plan of care.
  - ♦ Encourage and develop a plan for labor and delivery, which includes a support person and transportation.
  - ♦ Assist in obtaining an infant safety seat and advise the client on the infant safety law and seat usage.

Note: The Maternity Care Coordinator has a legal obligation to report situations of clear and imminent danger to the appropriate authority.

5.3 Plan of Care

The purpose of the plan of care is to document the work being done by both the family and the Maternity Care Coordinator. Agencies with Maternal Outreach Worker programs must also document Maternal Outreach Worker duties on the plan of care. Key points in the development of the plan of care include:

- the agreement between the client and the Maternity Care Coordinator on areas to be addressed, including priorities identified by the client
- care coordination goals and activities written in clear, behavioral terms indicating specific responsibilities and time lines for accomplishment/ reassessment
- strengths identified as resources
- modification according to changes in identified needs

5.4 Subsequent Contacts

Maternity Care Coordination subsequent contacts must be one-on-one, face-to-face visits conducted in the clinic, home or a convenient site. The subsequent contact may also be an exchange of information by telephone or letter. Although frequency and duration of services are to be determined by the needs of the client, **a minimum monthly contact is required**.

The Maternity Care Coordinator is responsible for ensuring that mandated follow-up of missed appointments occur.

Subsequent contacts should be individualized and include the following:

- number and complexity of problems
- availability of caregivers within the area
- availability of services within the area
- client's and her family's ability to meet their own needs and use available support systems

During the subsequent contact, the Maternity Care Coordinator must:

- review the Family Strengths/Needs Assessment for new concerns or changes in the status of previously identified concerns
- reassess the priorities of the client
- assess and reassess the family/client relationships
- update and revise the plan of care as needed
- make necessary referrals and follow-up on previous referrals
- discuss the future plans and/or transitions to other programs or services

5.5 Home Visits

Maternity Care Coordination home visits must be one-on-one, face-to-face visits conducted in the client's home. A home visit is determined to be necessary when it is needed to implement the developed plan of care or to prevent the client from discontinuing services. Home visits are considered subsequent contacts and meet the minimum monthly contact requirement.

In addition to the requirements outlined in subsequent contacts, the home visit must also include one or more of the following:

- assessment of the home environment
- monitoring of the client's adherence to their plan of care
- education/counseling
- referral and follow-up
- other support services, as needed

5.6 Transfer

The client may elect to obtain Maternity Care Coordination services from another provider. In this case, the transferring Maternity Care Coordinator must coordinate activities by:

- obtaining a signed medical release of information
- updating the plan of care
- notifying appropriate caregivers of status change
- initiating contact with the new Maternity Care Coordinator by letter/telephone to review the client's file and share significant information
- discussing transfer of services with the client and assisting with information regarding the new provider
- transferring a copy of the care coordination record(s) including all required forms

A new Letter of Agreement must be signed by the new Maternity Care Coordinator and the client once the transfer is complete.

5.7 Discontinuation

Maternity Care Coordination services can only be discontinued for the following reason(s):

- services are terminated at the end of the month in which the 60th postpartum day occurs
- client transfers out of the county
- client states she no longer wishes to receive services
- client is lost to follow-up after repeated attempts to locate her
- client expires during the eligibility period
- client is no longer Medicaid-eligible

5.8 Transition

The Maternity Care Coordinator must provide follow-up services to the mother and infant when transitioning the family to the Child Service Coordination program. The transition must include the following:

- Follow-up Services for the Mother:
  - ♦ Assist in locating a medical provider for her ongoing health needs.
  - ♦ Refer and assist in obtaining appropriate family planning services.
  - ♦ Provide and assist with information on community resources.
  - ♦ Provide and assist with information on parenting and well child care.
  - ♦ Refer and arrange for postpartum WIC certification.
  - ♦ Notify the client and caregivers that Maternity Care Coordination services are being discontinued.
  - ♦ Ensure that the Pregnancy Outcome Summary/Report has been completed correctly and has been submitted.

- Follow-up Services for the Infant:
  - ♦ Ensure that the local department of social services has been notified of the infant's birth and that the newborn has received Medicaid certification.
  - ♦ Assist in locating a medical provider for ongoing well child and sick care.
  - ♦ Ensure that the mother has the Health Check program brochure and understands that preventive services are available for children under the age of 21.
  - ♦ Consult with the local Health Check program coordinator regarding medical appointments for the infant and arranging medical transportation.
  - ♦ Refer and arrange for WIC certification for the infant.
  - ♦ Inform and assist the mother on the use of infant/child safety seats.
  - ♦ Coordinate the transition of care coordination services with the Child Service Coordinator.

5.9 Closure

Maternity Care Coordination services must be closed when one of the discontinuation provisions specified in **Section 5.7, Discontinuation**, occur. The Maternity Care Coordinator must:

- provide and assist with information on community resources
- update the plan of care to reflect the final Maternity Care Coordination service status
- notify the client and caregivers that Maternity Care Coordination services have terminated
- document reason for termination

When Maternity Care Coordination services are discontinued at the client's request, the Maternity Care Coordinator should:

- consider transferring the case to another Maternity Care Coordinator; or
- follow-up after termination to determine if the client would like to re-enroll.

5.10 Evaluation and Reporting

In order to collect data necessary for measuring the effectiveness of Maternity Care Coordination services, Maternity Care Coordinators are responsible for completing a Pregnancy Outcome Summary/Report for each client upon the completion of care coordination services. The Pregnancy Outcome Summary/Report must be submitted within 30 days of discontinuation of services.

Local health departments must complete the Pregnancy Outcome Summary (DEHNR 3080). This data must be submitted through the Health Services Information System (HSIS).

All other Maternity Care Coordination provider agencies (i.e., Federally Qualified Health Centers, Rural Health Clinics, physicians) must complete the Pregnancy Outcome Report (DMA-3002 Rev. 9/99). This report is submitted to:

Baby Love Program
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501

6.0 Providers Eligible to Bill for the Service

Community and migrant health centers, Federally Qualified Health Centers, local health departments, private practitioners, regional perinatal providers, and Rural Health Clinics are e ligible to provide this service.

The caseload size for a full-time Maternity Care Coordinator is 100 clients per year or 60 to 70 clients at any given time.

6.1 Provider Enrollment

1. Provider Application – A signed provider application (DMA-3008) must be on file for each agency that provides Maternity Care Coordination services.
2. Approval – The Division of Public Health and the Division of Medical Assistance must approve the application.
3. Termination – Provider participation can be terminated in accordance with provisions contained within the agreement.

6.2 Staffing Qualifications

This service must be rendered by:

- a registered nurse (RN) who is licensed in the State of North Carolina with a minimum of one year of experience in community health nursing and working with pregnant women and families;
- a Social Worker with a Master's Degree in Social Work, Bachelor's Degree in Social Work or employed as a Social Worker meeting state SW II qualifications with a minimum of one year of experience in health and human services and working with pregnant women and families; or
- a Maternity Care Coordinator trainee who is either:
  - ♦ an RN who is licensed in the State of North Carolina; or
  - ♦ a Social Worker with a Master's Degree in Social Work, Bachelor's Degree in Social Work or employed as a Social Worker meeting state SW II qualifications.

When additional years of experience are needed to meet the required number of years for SW II qualifications, the work experience requirement cannot be waived.

The work experience requirement is waived when the trainee is an RN, BSN, BSW or MSW. The trainee must work under the supervision of an experienced Maternity Care Coordinator. The duties and functions of a trainee are the same as outlined for the Maternity Care Coordinator. This includes carrying a caseload and does not require the signature of the supervising Maternity Care Coordinator. The supervising Maternity Care Coordinator must:

- arrange informal weekly conferences with the trainee
- provide timely access for the trainee
- assure supervisor and trainee relationship is defined in the agency policy

6.3 Staffing Requirements

The Maternity Care Coordinator must be:

- employed by a qualified service provider; and
- required to attend state-sponsored "Basic Training" within one year of hire date

Note: Student interns cannot provide Maternity Care Coordination services for Medicaid reimbursement.

7.0 Additional Requirements

Documentation

At a minimum, the client's record must include the following documentation:

1. signed Letter of Agreement;
2. completed Family Strengths/Needs Assessment;
3. plan of care;
4. dates of client contact/attempt;
5. type of contact (face-to-face, home visit, exchange of information by telephone);
6. actions taken from previous contacts/problems resolved;
7. plan of care concerns addressed during the contact and the actions to be taken by the client and the Maternity Care Coordinator before the next contact;
8. modifications to the original plan of care;
9. next scheduled contact;
10. total service time component (ex: 35 minutes = 2 units); and
11. signature of the Maternity Care Coordinator.

Documentation of contacts can occur on narrative notes (DMA-3016 Rev. 7/99), care plans (DMA-3007 Rev. 7/93) or Subjective data, Objective data, Assessment, and Plan of Action (SOAP) notes.

When applicable, agencies may opt to develop their own equivalent forms. However, components of the local forms must contain all the elements of the state-created forms and must be approved by the regional social work consultant prior to implementation.

8.0 Billing Guidelines

Reimbursement requires compliance with all Medicaid guidelines.

Maternity Care Coordination services are reimbursed up to six units per month. One unit = 15 minutes. Additional units may be requested through the claims adjustment process. Claims for additional units will be considered for reimbursement only when conditions of coverage are met and documentation supports the following medical necessity factors (or high-risk criteria):

- medical high-risk factors related to pregnancy outcome such as preterm labor, hypertension, preeclampsia, diabetes, suspected fetal growth retardation, multiple pregnancy, renal disease, HIV infection/AIDS, perinatal substance abuse and/or other high-risk medical conditions
- substance abuse (alcohol or drugs) or history of substance abuse with potential negative impact on current pregnancy
- child abuse or family violence with potential negative impact on current pregnancy
- mental impairment/retardation

Maternity Care Coordination must be billed per date of service.

Maternity Care Coordination services cannot be reimbursed when provided on the same date as the following services:

- Child Service Coordination
- Home Visit for Newborn Care and Assessment
- Home Visit for Postnatal Assessment and Follow-Up Care
- Maternal Care Skilled Nurse Home Visit
- Maternal Outreach Worker services

If a Health and Behavior Intervention home visit is determined to be necessary during a Maternity Care Coordination home visit, bill only one service.

8.1 Claim Type

CMS-1500 (HCFA-1500)

8.2 Diagnosis Codes That Support Medical Necessity

V22.0	Supervision of normal first pregnancy
V22.1	Supervision of other normal pregnancy
V22.2	Pregnant state, incidental
V23.0	Pregnancy with history of infertility
V23.1	Pregnancy with history of trophoblastic disease
V23.2	Pregnancy with history of abortion
V23.3	Grand multiparity
V23.4	Pregnancy with other poor obstetric history
V23.5	Pregnancy with other poor reproductive history
V23.7	Insufficient prenatal care
V23.81	Elderly primigravida
V23.82	Elderly multigravida
V23.83	Young primigravida

V23.84 Young multigravida
V23.89 Other high-risk pregnancy
V23.9 Unspecified high-risk pregnancy
V24.0 Immediately after delivery
V24.2 Routine postpartum follow up

8.3 Procedure Code(s)
HCPCS code T1017 – Targeted case management, each 15 minutes

8.4 Reimbursement Rate
Providers must bill their usual and customary charges.

9.0 Policy Implementation/Revision Information

Original Effective Date: October 1, 2002

Revision Information:

Date	Section Revised	Change
9/1/05	Section 2.0	A special provision related to EPSDT was added.
9/1/05	Section 8.0	Text stating that providers must comply with Medicaid guidelines was added to Section 8.0.
12/1/05	Section 2.3	The web address for DMA's EDPST policy instructions was added to this section.